

Sexually transmitted diseases in Botswana

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The Country

Botswana is a republic lying at the centre of the southern African plateau at a mean altitude of 1000 metres with elevations up to 1500 metres. It is about the same size as France, with an area of 224 712 square miles of which the Kalahari Desert takes up about 80%.

Botswana has been inhabited for a very long time, probably for half a million years at least. Censuses have been taken since 1904. The 1981 census showed a total of 936 000 people counted in the country. This was an increase of 63% over the 1971 figure, giving a yearly growth rate of 5%. The estimated crude birth rate is 50.8 per 1000, giving a natural increase rate of 3.5%.

The Batswana are predominantly agrarian cattle owning people, and the lingua franca of the ordinary people is Setswana, the most widely spoken African language in southern Africa. English is the joint official language.

The climate is continental and semi arid. The average rainfall is 18 inches, but yearly amounts vary considerably and distribution through the season (October to April) is usually erratic. This leads to frequent droughts and crop failures, which have occurred in recent years.

HISTORY

Botswana's first contacts with Britain were in the nineteenth century through missionaries, such as Robert Moffat and later David Livingstone. Towards the end of the nineteenth century trouble between the Batswana and the Boers resulted in the Batswana appealing to Queen Victoria, and in 1895 Botswana, then called Bechuanaland, accepted the protection of Britain. Thereafter constitutional development was slow until self government was granted in 1965. In 1966 the country became an independent republic.

ECONOMY

Botswana was one of the poorest countries in the world at the time of independence; its economy was based on traditional cattle raising and was heavily dependent on South Africa. Considerable foreign aid and the discovery of deposits of copper, nickel, and diamonds have changed the country's prospects dramatically.¹

MEDICAL SERVICES

With the considerable development in recent years, the provision of health care has not been forgotten. Before independence the medical services were rudimentary and based essentially on mission hospitals. Now there is a well equipped hospital in every large town, though facilities are often inadequate for the growing population. Villages have primary health care clinics staffed by trained nurses. Nurses are trained within the country, but there is no medical school in Botswana. Doctors therefore have to be trained elsewhere, and there are still not enough Batswana doctors practising in the country.

Much foreign aid, mainly from Scandinavian countries, the United Nations, and the World Bank, has been made available for health care. Expert advice is available to the Ministry of Health, which has adopted a sensible pragmatic approach to the provision of medical services with the emphasis on the development of good primary health care. Health education, the improvement of water supplies, the provision of adequate midwifery services, and the control of tuberculosis all receive high priority. There is a small private medical sector in the main towns and cities.

SEXUALLY TRANSMITTED DISEASES (STD)

Livingstone, travelling in Bechuanaland in 1857, wrote that syphilis was unable to maintain itself in any form in people of pure African blood anywhere in the centre of the country. Warren, however, during his expedition to Bechuanaland in 1885, found "the natives to be badly affected". In 1887 the district surgeon, Dr Bedford, found that more than half the 5529 "natives" examined by him had syphilis.² Merriweather documented endemic syphilis in the northern part of the country in the 1950s,³ which was

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probably similar to that seen by Willcox in Southern Rhodesia.⁴ It has not been recognised recently.

Most doctors in Botswana know that there is a high incidence of STD in the country now, but this has not been properly quantified. The Ministry of Health, however, recognises that a substantial problem exists, and in 1980 devoted one of its monthly epidemiological bulletins to it.⁵ Between 1976 and 1979 it was found that 8% of all out patient attendances were for STD, making this group of diseases the third or fourth most common reason for attendance at an out patient clinic. Gonorrhoea alone accounted for 5.1% of all visits.⁶

No clinics are dedicated to the diagnosis and treatment of STD in Botswana. Patients are seen at the primary health care facilities and in hospital out patient departments. Diagnoses are usually made on clinical grounds, and almost no laboratory back up is available. Microscopes are not available in the out patient setting. Culture for the gonococcus is therefore rarely carried out, and testing for β -lactamase producing strains has never been undertaken. The Venereal Disease Research Laboratory (VDRL) test is available in hospitals with laboratory facilities; no specific tests for syphilis are used. Syphilis is the most common diagnosis made in people with genital sores, which is surprising as chancroid is the most common cause of genital ulceration in the surrounding countries. Of the patients shown to me in several parts of Botswana, however, chancroid was the commonest clinical diagnosis. Lymphogranuloma venereum is also often seen. Non-gonococcal urethritis is rarely diagnosed but, with the high incidence of chlamydial infections recognised in neighbouring South Africa, and with the movement of the labour force between the two countries, it would be surprising if this disease

was not widespread in Botswana also. The presence of a vaginal discharge is often taken as evidence of a "venereal" infection, and such a diagnosis is included in out patient figures, though the grounds for such labelling seem obscure.

THE FUTURE

The Ministry of Health now wishes to address the problem of the control of the STD, and funding may soon be available to set up a control programme. The 1984 annual congress of the Botswana Medical and Dental Association devoted a whole session to the STDs. Many views were expressed as to the best way of embarking on their control, making allowances for local attitudes and customs. Training medical and nursing staff was seen to be of the utmost importance, and there was general agreement that a model clinic with suitable laboratory facilities should be opened in the capital city, Gaborone. Considering the success that the Ministry of Health has had with other carefully planned control programmes, there seems to be every hope that the STD in Botswana will soon be more reliably and efficiently diagnosed and treated.

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